Notice is hereby given that a meeting of the Council of Governors
of Heart of England NHS Foundation Trust will be held at
the Harry Hollier Lecture Theatre, Partnership Learning Centre, Good Hope Hospital
on 7 October 2015 from 4.00 to 6.00pm

A G E N D A

		Timing (mins)
1.	Month 5 performance, financial position and recovery plan (Oral – J Brotherton/ A Catto/ H Gunter /D Cattell)	20
2.	Reports from CoG Cttee chairs:	
	a. Audit Appointments Committee (22.09.15) (Oral - R Hughes)	5
	b. Finance & Strategic Planning (21.05.15, 15.09.15) (Enclosure & Oral– M Trotter)	5
	c. Hospital Environment (09.07.15, 10.09.15) (Enclosure & Oral – E Coulthard)	5
	d. Patient & Staff Experience (25.09.15) (Enclosure - M Kelly)	5
	e. Quality & Risk (09.07.15, 28.09.15) (Enclosure & Oral – M Pearson)	5
3.	Priority Programme for Frailty (Enclosure - Prof Ian Philp)	30
4.	Dementia Friends (Oral - M Meixner & D Naylor)	30
5.	CEO Recruitment update (Oral – Chair)	5
6.	Any other business previously advised to the Chair	

Next Meeting – 4 November 2015 – St Johns Hotel, Warwick Road, Solihull

Refreshments will be available from 3.00pm when NEDs will be available to Governors

Kevin Smith
Company Secretary
30 September 2015

COUNCIL OF GOVERNORS
Finance and Performance Strategic Planning Committee
Of the Council of Governors of Heart of England NHS Foundation Trust
held on Thursday 21st May 2015, 10:00hrs
in the Boardroom, Devon House, Heartlands Hospital

Present:	Mr Albert Fletcher
	Mrs Kath Bell
	Mr Michael Hutchby
	Mr Barry Orriss
	Mr Philip Johnson
	Dr Olivia Craig
In Attendance:	Mr Jonathan Gould
	Mrs Angeline Jones
	Mr Stephen Lewis
	Ms Hazel Gunter (p/t)
	Ms Jenny Hall (Minutes)
Partial Attendance:	Professor Matthew Cooke
	Mr Simon Birley

1. APOLOGIES FOR ABSENCE

Apologies were received for: Mr M Trotter, Mrs J Hodgkiss, Mr R Hughes, Mr D Cattell and Mrs M Vaughan.

2. MINUTES OF THE MEETING HELD ON MONDAY 30TH MARCH 2015

The minutes of the meeting held on 30th March 2015 were accepted as an accurate record.

3. MATTERS ARISING/ ACTION LOG

Chairperson
Following recent discussions regarding Chairperson, Mrs Bell and Mr Trotter were nominated as new Chairpersons. Following a vote, Mrs Bell was elected as Chairperson and Mr Trotter will be invited to become Vice Chairperson.

Fraud Policy for Finance Director Fraud
Mrs Jones is currently seeking advice from the Counter Fraud team regarding appropriate wording in this policy. Feedback will be provided at the next meeting.

Alternative venues for Council of Governor meetings
Meetings have now been rotated across the three sites as requested.

4. HR STAFFING PROCESSES AND CONTROLS

During previous meetings there have been issues raised in regards to overspend on bank and agency staff throughout the Trust and the effect use of agency has on staff morale and patient experience.
Ms Gunter explained there are currently problems throughout the region with recruiting Band 5 nurses in particular, and with retaining staff once recruited.

In this Trust sickness and turnover is high. Approximately 26 nurses (1 per day) leave the Trust and a report has been presented to EMB and F&PC, setting a trajectory for recruitment in order to maintain existing staffing levels.

In addition, Finance & Operations are completing capacity work to review the expected demand for beds over the next 12 months. This may mean flexed capacity which has been staffed with temporary staffing will be given funding which will mean those posts become part of establishment and can be recruited to permanently.

Ms Gunter presented the Workforce Delivery Unit Dashboard which illustrated the majority of bank and agency usage as a result of temporary capacity remaining open. Ms Gunter explained the majority of leavers are staff within two years of completing their nurse training. This indicates further work is required on leadership, maintaining educational support and personal support for newly qualified staff. All staff leaving the Trust are offered an exit interview or given the opportunity to complete an online exit survey. Results are then collated and any obvious concerns are managed appropriately.

Mr Fletcher suggested there may be lessons to be learnt from organisations such as the RAF and the Army. Nurses appear to be supported and sponsored throughout their training as well as on-going throughout their career. Mr Fletcher asked this approach to sponsorship and recruitment is looked at with some veracity and an update is provided in October from HR.

Action: Mr Birley – 2015: Provide report on the possibility of sponsoring staff

The Trust has recognised more focus is required on staff engagement in order to improve morale. Andrew Foster has been involved in recent staff engagement events and is fully supportive of this approach. There have already been several staff engagement events throughout the Trust will further events planned. Specific sessions have been organised for Medics, Bands 1 to 4, Facilities and other Specialist staff groups. Andrew Foster chairs the staff engagement steering group where action plans for staff suggestions are generated and some of the quick wins are already being implemented, such as a hot air blanket for the main corridor and identifying a budget for new starters. Reduction of sickness and improved staff survey results suggests the feedback from staff engagement events has been positive.
Ms Gunter will provide the committee with a video which shows how staff engagement has made positive changes throughout the Trust.

Action: Ms Gunter to forward to Mrs Vaughan for circulation with final minutes.

Mr Orriss raised a query that despite previous comments he still felt that there was too many staff in the Good Hope Treatment Centre. Mrs Jones advised Theresa Price and the Matron had previously attended the committee to explain the various roles the Nurses complete. Mrs Gunter added Nursing and HR are reviewing whether a Band 4 nurse role can be developed where they will perform some of the Band 5 duties.

Other developments on staffing and culture included four values being agreed by the Board, a new appraisal system and new recruitment methods. Mr Birley explained the work being completed to support newly appointed staff, and helping them to settle in, such as accommodation, transport and mentoring support. Mrs Bell was interested in how we were linking local universities, and Simon outlined how the lead nurse was in regular contact with the 89 student nurses appointed from Birmingham City University who will start in September.

Mr Hutchby asked what impact the DoH proposals for 24/7 working would have on staffing and agency levels. Ms Gunter indicated the impact would be dependent on Trust strategy as not all services were required to be 24/7.

Action: Ms Gunter – October 2015: Provide update on staffing numbers and staff retention.

5. FINANCE AND PERFORMANCE MONTH 12

Month 12 figures

At month 12 the Trust had a COSR rating of level 4 (highest level) delivering a YTD deficit of £5.6m, as per the forecast The Service Improvement Efficiency Programme (SIEP) delivered £16.4m (68% of £24m target). Month 12 delivered 75% of the in-month target. The cash balance is £9m above plan. This is due to capital spend being behind plan offset by overspends on the income and expenditure account. Total capital spend in the year was £20.5m. Carry forward expenditure of £20m to 2015/16 was approved by Finance and Performance Committee.

62% of CQUIN targets have been met. Therefore as the Trust will exceed the 60% target set by CCGs, all CQUIN monies have been billed.

Mr Orriss raised concern in regards to failing the Performance Standards in a number of areas. Mrs Jones explained in the 2015/16 Plan additional investment had been allocated to spending on areas which would improve performance. Mr Gould outlined the Integrated Improvement Plan (IIP) had been signed off by Trust Board, the CCG and Monitor and brought together all the action plans to achieve the performance targets in the future.

Mr Johnson expressed concern Mr Foster had indicated a new building was the solution and he felt this could encourage more attendances. Professor Cooke explained the Trust needs better processes for treating patients in A&E but also better facilities were required.

Mr Fletcher asked what was needed to get back on target. Professor Cooke stated we needed to achieve the target sustainably and the plan was to be at this point by November 2015, as the engagement and culture parts of this programme of work would take time to have an effect.

Mr Orriss noted he had heard similar explanations before and wanted someone responsible for delivery of the targets and to come to the next meeting.

Action: Agreed to request Mr Catto to present the IIP at the next meeting.

6. "DRAFT" CORPORATE STRATEGY UPDATE

Professor Cooke presented the updated draft Corporate Strategy.

It was clear from the recent staff engagement events, many staff were still not aware of the Trust's vision. Professor Cooke is coordinating the development of a new Trust Strategy. The Trust is currently engaging with staff, patients and other stakeholders on what the Trust vision should be. This includes considering whether we are 3 hospitals on a number of sites, whether we are a teaching hospital and/or an academic Trust and where are the areas we want to expand and what are we not going to do. The Strategy will be presented at September's Board.

Action: Professor Cooke to email electronic presentation with the final minutes.

Professor Cooke outlined the strategic projects already in progress:

- Surgical reconfiguration will have a CCG led public consultation in September with a decision in December and first move in April 2016.
- Solihull Urgent Centre (UCC) will go out to tender in the summer with changes taking effect from September 2016.
- A Frail Elderly Care Strategy is being developed and a new Deputy Medical Director to specialise in this area has been appointed.

Mr Johnson asked how the Trust was dealing with population changes, i.e ageing and increasing population, as well as planned housing movements. Professor Cooke responded these should be easy to predict and will be included in planning.

Mr Orriss asked how we respond to the needs of non frail elderly patients and Professor Cooke added the elderly fit were an emerging patient class and services such as trauma would be developed to cater for this.

Dr Craig reiterated the importance of dementia planning in the strategy.

7. ANY OTHER BUSINESS

- Mrs Bell requested her previous queries be responded to and Mrs Jones agreed to speak after the meeting. **A Jones**
- Professor Cooke to find out details in regards to dementia research funding received by the Trust. **Prof Cooke**
- Professor Cooke advised the national audit figures for the newly implemented hyper acute stroke services show improved performance. The report to be circulated for information. **M Vaughan**

DATE AND TIME OF THE NEXT MEETING

TUESDAY 15th SEPTEMBER AT 15.00hrs SOLIHULL EDUCATION CENTRE,
(please check plasma screen on arrival)

Chairman …….. Dated .....

COUNCIL OF GOVERNORS
HOSPITAL ENVIRONMENT COMMITTEE

Minutes of a meeting of the Council of Governors Hospital Environment Committee, held at 2.00 p.m. on Thursday, 9 July 2015, in Room 2, the Education Centre, Solihull Hospital

PRESENT: Elaine Coulthard (Chair)
Andy Edwards
Sue Hutchings
David Treadwell
John Sellars

IN ATTENDANCE: Karen Tongue, Operations Lead for Asset Management
Kathleen Bell, Governor
Ann Harwood, Executive Assistant (minutes)

NOT PRESENT: Carol Doyle
Arshad Begum
Ron Handsaker
Richard Hughes
Marek Kibilski

15.29 APOLOGIES
There were no apologies.

Elaine Coulthard had invited Kathleen Bell to attend the meeting as a guest.

The Governor's agreed that David O'Leary would be sadly missed.

15.30 MINUTES OF THE MEETING HELD ON 7 MAY 2015
The minutes of the meeting held on 7 May 2015 were approved as an accurate record.

Veronica Treadwell had asked for her thanks and appreciation to be passed on to members for allowing her to attend the Chest Clinic walkabout and meeting on 7 May 2015.

15.31 MATERNITY AND NEO-NATE PROJECT

- Kathleen Bell queried whether the Maternity and Neo-Nate project at BHH would still be going ahead. John Sellars advised that this project is on hold, pending the outcome of the Trust's Clinical Strategy review and subsequent agreement of the Capital Plan and Estates Strategy. As part of the Estates Strategy a decision will need to be made on whether to proceed with the current proposals for Maternity and Neo-nates in its current location with an extension, or whether to include this scheme in the proposals for a new Tower Block. John Sellars confirmed that no new capital work is currently being undertaken until the Estates Strategy has been agreed. The Dermatology project at SH and Hybrid Theatre project at BHH are continuing but all other capital projects are on hold, including Maternity & Neo-nates, A&E, ITU and Interventional Radiology at BHH, Surgical Reconfiguration at SH and the GHH car park scheme.
- Kathleen Bell was concerned that there are some problems with the flooring in some areas of the existing Maternity building, particularly on the Ground Floor adjacent to the theatres where the floor is lifting and cracking. She felt that extensive works are required to resolve this issue or that

  a new build is required. Andy Edwards queried whether remedial works should be carried out as part of backlog maintenance. John Sellars advised that there is a structural problem with the

floors in this unit, in the meantime some patching works will be carried out to resolve the immediate problem.

- John Sellars confirmed that issues reported in the CHC inspection reports will be picked up if there are any health & safety concerns and any issues reported from the PLACE inspections will be picked up as a priority. John Sellars also confirmed that a 6 facet survey of the entire Trust Estate has been carried out.

15.32 ACTION SHEET FROM MEETING HELD ON 7 MAY 2015

15.32.1 Terms of Reference

It was noted that the Terms of Reference remain as agreed by the Hospital Environment Committee previously. They are now with Kevin Smith to give final approval, ensuring that they fit with the TOR for all Council of Governors committees and other Trust committees.

15.32.2 Ward 3 at BHH

The action re the temperature on ward 3 will be picked up in October, November and December. John Sellars will report back to the January meeting.

15.32.3 Restaurant at GHH

Following a query raised by Elaine Coulthard at the May meeting, John Sellars confirmed that the sandwiches on sale in the Costa Coffee shops at GHH are provided on a 'sale or return' basis by Ginsters, there is therefore no waste or additional cost incurred.

15.32.4 Main Corridor Roof Leak at GHH

The leak to the main corridor roof at GHH has now been repaired.

15.32.5 Devon House Car Parking Barriers

John Sellars confirmed that a bid has been submitted to install a different type of barrier to the current triangles in use outside Devon House.

15.33 TERMS OF REFERENCE

The Terms of Reference were discussed under item 15.32.1. Kevin Smith is working on a standard layout and format for all Committee Terms of Reference.

15.34 DEMENTIA STRATEGY

Karen Tongue, Operations Lead for Asset Management, attended the meeting to give a presentation on the Trust Dementia and Delirium Strategy. Apologies had been received from Niall Fergusson, Consultant in Elderly Medicine, who had been invited to assist in giving the presentation. The following points were noted/ discussed:

- The Process Redesign Team is assisting in the development of the Dementia Strategy from a project support point of view.
- Dementia is diagnosed for patients with a range of conditions/ symptoms associated with gradual deterioration of brain function. Whereas delirium is an acute phase of an illness/ infection which affects a patient's reasoning in a similar way to Dementia, but is a temporary condition. Patients with Dementia experience difficulties with their physical environment and a loss of visual perception.
- David Treadwell queried why the number of patients with Dementia is increasing. It was noted that this is mainly due to the fact that people are being kept alive for longer. Figures produced by the Alzheimer Society show that the number of patients diagnosed with Dementia in the UK is predicted to increase year on year to around 1.7 million in 2051.
- Work on the Trust Dementia and Delirium Strategy commenced in September 2014. A Dementia Board has been set up which is Chaired by Niall Fergusson and Sam Foster, Chief Nurse, is the

  Executive Lead. There are five workstreams, one of which relates to environmental factors and this is the workstream that the Process Redesign Team is involved in.

- More work is required on engagement and involving the right people. Elaine Coulthard advised that Dementia training is being carried out at GHH, however junior staff in A&E at GHH are not receiving this training. Karen Tongue agreed to feed this back.
- David Treadwell was concerned about patients with Dementia being cared for in an acute setting. Karen Tongue advised that the aim is to care for Dementia patients at home/ in the community. Dementia patients are only admitted into an acute hospital if they are suffering from an acute illness and are then discharged back into the community as soon as they are well enough. There needs to be sufficient support services available to provide care for Dementia patients in the community.
- To improve the environment for the care of Dementia patients a set of design principles has been agreed some of which will be tested in the new Dermatology facility at Solihull Hospital.
- A new National HBN has been produced which includes Dementia care.
- There are 14 recommended core elements to providing a Dementia friendly environment. Examples of these include identifying handrails around toilets in the same colour as the toilets; nurse stations/ reception areas to be sited at the front of wards/ departments; appropriate signage and way finding. However it was acknowledged that any changes made to the environment will need to be managed within existing facilities.
- Elaine Coulthard stated that Dementia friendly clocks should show the day of the week, month and year. Karen Tongue advised that this could be shown on patients' bedside TVs.
- The Dementia friendly principles were included in the design for Ward Block 1 at GHH, these include sanitary ware, artwork landmarks, corridors have good natural light and orientation, focal points are highlighted in distinguishable colours. These principles will be included in all new builds.
- Sarender Chana, Head of Design and Compliance, is leading on the Trust Wayfinding Strategy which will include Dementia friendly principles.
- It was agreed that a visit to the new Dermatology facility would be arranged for members to view the Dementia friendly facilities once the unit is open.
- Members thanked Karen Tongue for giving a good presentation and asked that their thanks be passed on to the team who had been involved in preparing the presentation.

- David Treadwell was keen for the Hospital Environment Committee Governors to be seen to be making a difference. Elaine Coulthard suggested that it may help if members could spend half a day per month visiting their nearest hospital, going round the public spaces, talking to staff, and then reporting back to the Committee. Elaine is already involved at GHH and it was suggested that Sue Hutchings could visit SH on a monthly basis. It was noted however that the Non-Executive Directors attend organised visits, there are also the PLACE and CHC inspections. It was agreed that if these monthly visits were to take place it would be courteous to let the site teams know in advance. This approach would also need further discussion/ agreement in the first instance.

15.35 CAR PARKING REPORT

John Sellars presented an update report on car parking facilities and improvements across the Trust. The following points were noted/ discussed:

- Elaine Coulthard was concerned that hospital volunteers are given free parking permits for the staff car parks at GHH immediately whereas staff have to wait at least 6 months for a parking permit and this is not on a 'first come, first served' basis, she felt that volunteers should be given free parking in the public car parks instead. Elaine has contacted Andrew Foster, as she is concerned that the Trust is losing too many clinical staff to agencies and feels that the Trust should be doing everything possible to retain their clinical staff. She also felt that clerical staff at GHH could use the main public car park in Sutton Coldfield, therefore freeing up space in the staff car parks for clinical staff. John Sellars advised that the parking situation at GHH for visitors and

  patients is already very tight and confirmed that it is Trust policy to prioritise visitors parking. He also advised that if staff transfer to agencies they will be in the same position with regard to

parking on site. It was agreed that as the Trust Car Parking Policy is due to be reviewed these points could be considered as part of the review.

- Elaine Coulthard was also concerned about the parking machines which won't take 5p coins and are unable to give 5p in change. John Sellars reported that in 2014 the proposal to increase parking charges had not been accepted, this would have resolved the 5p issue. A way forward has been agreed whereby patients/ visitors will not be charged the additional 5p and will therefore make a 5p saving. Temporary notices advising of this change will be attached to the car parking machines until the charges are reviewed as part of the Car Parking Policy review.
- Elaine Coulthard queried how old the Trust car parking machines are and who owns them. She was concerned about the car parking machine at the Richard Salt end of GHH, which is often out of order. John Sellars confirmed that the Trust owns the car parking machines and that they are under contract for maintenance.
- Elaine Coulthard advised that there are consultants at GHH who are parking inconsiderately across two bays which reduces the number of available spaces. She queried whether car parking staff could place stickers on these cars. John Sellars stated that the Trust car parking officers are also security officers and therefore are not able to continuously monitor parking across the site, they do however place stickers on cars immediately where they are found to be parked dangerously or on red lines. In all other cases where cars are parked inappropriately/ inconsiderately, three warnings are issued and in all cases the car parking/ security officers will take a photograph of the offending car. John Sellars asked Elaine Coulthard to let him know which consultants are parking inconsiderately so that this can be picked up.
- It was noted that due to the number of complaints regarding issues occurring at the Yardley Green Road entrance to the BHH site, the security officers manning this gate are now wearing body cameras so that any incidents will be recorded/ witnessed.
- Additional security/ car parking resource has been taken on which includes a car parking/ security officer to deal with queries between 8.00 a.m. to 4.00 p.m. Members agreed that the car parking/ security officers have a difficult job.
- The multi-storey car park on Yardley Green Road is a staff car park and the Trust is looking at purchasing additional land on Yardley Green Road to provide further staff parking. This will free up more spaces on the BHH site for patient/ visitor parking.
- Sue Hutchings raised a concern that cars are being driven over pedestrian walkways to gain access to car parking spaces at Solihull Hospital. John Sellars agreed to arrange for this issue to be looked into.
- Elaine Coulthard was concerned that people are parking either side of the pedestrian crossings adjacent to the Main Entrance at GHH. John Sellars advised that people are using this area as a drop-off point for Maternity.
- Elaine Coulthard also raised the issue of people smoking outside the Maternity Unit despite there being a number of notices displayed advising that the smoking shelters should be used. John Sellars advised that the Trust No Smoking Policy is currently being reviewed. It was acknowledged that although it is everyone's responsibility to ask people to move to a smoking shelter, this can be difficult to do.
- John Sellars confirmed that the GHH multi-storey car park scheme is currently on hold until the Trust Clinical Strategy has been agreed and the Estates Strategy approved. There are various options for the build which will be a permanent car park with either a structural steel framework or built from re-enforced concrete. The new car park will provide a nett increase of 300 spaces on the GHH site. Andy Edwards advised that each car parking space will cost approx £5k.
- The Car Parking Trading Account was discussed. John Sellars confirmed that all parking income comes to the Trust. Approx 15% of this income is paid to G4S for the provision of Security and Car Parking services, the remaining 85% is used to offset all remaining car parking costs including capital charges, maintenance, lighting etc. Overall the Trust achieves a break-even position. It was noted that to provide free car parking would cost the Trust approx £4m per annum.

- David Treadwell queried whether any bus services enter the BHH site. John Sellars stated that they don't although this has been looked at in the past in conjunction with West Midlands Travel.

- Elaine Coulthard was impressed with the electronic screens which have been installed in the Trust displaying bus timetable information.

15.36 CATERING REPORT

John Sellars presented a report for information on retail catering outlets across the Trust. The following points were noted/ discussed:

- The report details information on all the retail outlets across the 3 hospital sites, including the unit type, site/ location, operator, items sold, improvements and initiatives undertaken to date and future plans.
- Since the previous Monday all patient sandwiches are being made in-house and distributed from the CPU. This initiative is costing the Trust an additional £25k per annum but is providing a better quality product.
- All inpatient food for the 3 hospital sites is prepared in the CPU at SH.
- At BHH all the catering outlets for staff, visitors and outpatients, are outsourced.
- The Costa Coffee outlets are run on a franchise basis.
- David Treadwell queried whether consideration has been given to privatising catering services. John Sellars advised that there are no plans to privatise this service and there are no reasons to do so. The Board of Directors would need to approve any proposal to privatise the service.
- Members were very impressed with the CPU and the food provided for inpatients.

15.37 ANY OTHER BUSINESS

There was no other business.

It was agreed that the next meeting in September would commence with a walk round the new Hybrid Theatre facility at BHH.

Post Meeting Note: the new Hybrid Theatre facility opens at the end of August and will therefore be in use on 10 September. It was agreed with Elaine Coulthard to hold the September meeting at Solihull Hospital and incorporate a visit to the new Dermatology Unit.

15.38 DATE OF NEXT MEETING

2.00 p.m. on Thursday, 10 September 2015,
in the Seminar Room, Dermatology Unit, Solihull Hospital

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Chairman

PATIENT EXPERIENCE
COMMITTEE OF THE COUNCIL OF GOVERNORS
MEETING
Friday 25th September 2015 at 14:30
Boardroom, Heartlands Hospital

Attendees
Sue Hutchings
Mike Kelly – Chair
Margaret Meixner
David Treadwell

Apologies
Arshad Begum
Dawn Chaplin
Elaine Coulthard
Frances Linn
Elaine Tandy
Sandra White

In Attendance
Peter Colledge
Mick Corser
Jamie Emery
Helen Evans
Sam Foster
Tom Webster

Bev Bellerby - minutes

Welcome and Apologies
All were welcomed to the meeting. Apologies were received from those shown above.

Minutes of Previous Meeting and Actions Arising
As the minutes of the two previous meetings were some months previous, they were accepted as a true record.

DNA rates – Helen Evans
Helen Evans had been invited to the meeting to advise the attendees on the recent progress in reducing DNA (Did Not Attend) rates. Helen advised that she looked at the last 4 years. In 2010, the rate was 12.7% and was currently 9.7%. The national target is 11%.
New patients failing to attend their first appointment went from 12.87% down to 10.67%. 2014-15 saw 1 million OPD patients attending clinics which was on target again for the current financial year.
11.85% reduced to 9.25% for follow-up patients. Helen mentioned that all figures were Trust-wide. BHH was slightly higher than Solihull and GHH. Helen's team had done some work on that and discovered that even the BHH rates are lower than other hospitals in the area.
Currently, the DNA rate for the Trust stands at 10.3% but the team are always working to keep the percentage as low as possible.

All appointments are booked at Lyndon Place. Helen advised that a group of Governors attended the offices, as did members of Healthwatch, and they were impressed the work undertaken, there.
Helen added that the team are on line to centralise all OPD appointments by the end of the financial year; at present, not all specialties are booked via Lyndon Place.
Helen told the meeting that, at Lyndon Place, there is a 'one point of contact' call centre and 92% calls are answered first time. There was also a lot of information regarding DNAs on appointment letters. There is also an evening team, who call patients 2 weeks before their appointment dates. The patients can then reschedule, during that call, if necessary. Lyndon Place is open 08:00-20:00 and the evening team work 16:00-20:00, Monday to Friday. There is also an automated reminder service, which gives callers an option to divert to the call centre if they need to amend or cancel an appointment. Lyndon Place do not do text reminders yet, but that was likely to start in January 2016 as there had been an upgrade to the system, allowing staff to start using that method of contact.

Posters go up in clinics about DNA rates to keep patients informed about the importance of attending appointments and there is now a new DNA policy which was agreed with Trust and CCGs. As part of a trial, Surgery and Dermatology patients will be sent a proforma to ask why they DNA their first appointment and fill out a form for a new appointment if they want one.
Analysis had been done on reasons why patients DNA and over 1000 patients were contacted.
The reasons why people did not attend were not the reason the staff were expecting. They were told that patients had other things to do, couldn't park, got lost, as well as other reasons for not attending.
Choose and Book is another way that patients can book appointments; either the GP or patient can book themselves on line. They are followed up with information after they have booked. However from 11th to 25th September, 174 of those patients that used the Choose and Book system did not attend their pre-booked appointment! Dr Alice Turner has set up a research group around why patients do not attend and Helen will be working with her.
Another idea was to ring every patient to remind them rather than sending patients' letter but would be a very big job and would need many extra staff.
Letters can be sent out in a larger font, which would be especially useful for ophthalmology and elderly patients. There was a discussion about sending eye letters out on yellow paper to make them easier to read. Helen had been speaking to external printers but was only in the early stages.
Tom Webster mentioned the yellow paper – he said that the tone of the yellow is relevant – gold yellow is the right tone not a light yellow. Helen thanked him for his input and advised that any changes would be taken to the ophthalmology experts before being launched.

Helen said that patients who DNA always thought they would get another appointment as HEFT did not strike patients off their lists.
Helen told the group that the costing gone up from £50 per attendance to £100, which meant that £1m per year is a likely figure for the cost of missed appointments. Helen added that there is always an expectation that 10% of patients will not attend and clinics are built around that.
Jamie Emery had done some work with oncology about sending out letters. He advised that a few people had looked at the letter to ensure it read in the best way to encourage

attendance. Helen added that even patients with expected cancer diagnosis still fail to attend, often because they are scared of the potential diagnosis.
Helen told the meeting that some of the messages around DNAs are to say how many attended in a time period, rather than how many do not. Tom Webster added that people think that it will not be a problem if the clinic is missing one person so it is OK for them not to attend as they are only one of many that will.
Helen told the group that areas that show a peak in DNAs will have extra work on those patient groups to try to work out why they do not attend. She is also looking at inpatients that do not turn up for surgery, etc. Helen is running a pilot for ENT and T&O, checking that patients are still fit to come in and don't need to reschedule.
More work being done with GPs; they must make sure their patients are available to attend appointments that they refer them for and the CCGs on board with the new agreement.
Helen will obviously be looking at costs around all of the things they are planning to do.

Quality Accounts – (Elaine Tandy)

Elaine Tandy was not able to attend the meeting but advised the meeting, in writing, that the Quality Account for 2014/15 was published on NHS Choices and the Trust website in June this year. The executive committee chose to continue with stroke, pressure ulcers and falls as priorities, in addition to an improvement in both the response rates and overall scores of the Friends and Family test in the Emergency Department. This reduces the number of priorities included in the quality account from 7 to 4, which is in line with the national guidance. Elaine's team have started meeting with the areas to see how the work is progressing and will produce a 6-monthly report to be presented to Audit Committee in November 2015. Elaine will bring that report to the next Patient Experience meeting, following Audit Committee. She had some mini-guides of the Quality Accounts for those that wanted them; extra copies could be obtained from Communications.

Update on Patient Experience and FFT and Complaints – Jamie Emery

FFT – Jamie Emery said that everything was in a better place, with a standard template and standards of reporting. All data goes to Quality and Risk for assurance.
All patient experience data will be visible on the nursing quality dashboard. Jamie has worked with the Performance team to get all of the nursing safety data in one place, which includes patient feedback and complaints. Ward leaders can now see everything they need for their areas; it is updated monthly. It is electronic but is also printed out and put on the ward and it provides good assurance for patients and visitors, alike.
FFT comments written on the cards have some really useful messages.
There is ongoing monitoring of FFT compliance at Nursing and Midwifery Performance Board.
Maternity, paediatrics and community services need updating but work is being done with those areas.
Three key areas; noise at night, information about discharge and buzzer response times, are fed back to the CCGs, as a national standard.
Inpatient satisfaction scores are improving. The same thing is happening in A&E and it had its highest score ever, recently (82%).
OPD scores are almost at 90%.17,000 people per month are completing the cards which is around 14% of total attendances.
Sue Hutchings asked how FFT was promoted. Jamie advised that patients should be asked to complete a card as they are leaving the area.

Sam Foster added that Ward Clerks and HCAs had been excellent, especially the Ward Clerk on Ward 3 and Sam was keen to ensure that staff that go the extra mile on FFT are thanked.

Complaints – last financial year approximately 3 in 1000 patients complained, either formally or informally through the PALS route. Following the peer review action plan, Helen Shoker has guided and supported the team.
CCG come into the Trust every quarter to look at complaint handling. They looked at the reopened ones but not all of them contained new issues. CCG suggested giving the complainant a date to close the complaints by, to identify if they are actually reopened with new issues or just talking about the same complaint, but in more detail.
Sam Foster said the peer review was poor but she said that the team have worked really hard to ensure that changes were rolled out. San wanted to thank Jamie and his staff for the progress they have made in such a short amount of time.
Jamie advised that the team now have a weekly complaints review meeting which didn't used to happen before the peer review. Live complaints had gone down from 275 to 200 just by looking into those open and reviewing them effectively. Some complaints were complex and could not be closed. The team had struggled without a progressive route to get a response from their colleagues, around the Trust. A template will be created soon to allow staff to move the complaint up the ranks, in the relevant department.
Mick Corser advised that complaints could be a positive thing, especially the way that you dealt with them. The meeting attendees agreed.
Tom Webster said that the present situation was to be commended. This committee can take some of the credibility for the pushing they did of Jamie and his team and he wanted to pass on his praise to the complaints team.
Jamie advised that the team are more explicit about telling complainants that they can go to the ombudsman, now, so referrals may increase, but the cases they take on should not increase, if they are being handled well by the Trust.
David Treadwell asked if the Trust had posters up from solicitors advertising for patients who wanted to claim. Sam Foster said the Trust did not allow that to happen.

Datix web is a new complaints handling database that has been given funding. It will help analysis by allowing easier input and extraction of data.
Helen Shoker is writing a business case around complaints structure across the three sites and there is now a good opportunity to shape and develop the team.
Also, the Trust complaints policy is being rewritten. D25 (today plus 25 working days) is doable for some complaints cases but not in others. Monitor look at the D25 standard and the new policy will mention a sensible timeframe as agreed with the complainant, instead. The department was looking into ringing patients rather than keep sending out unofficial letters. This relies on the doctors and nurses meeting with the complainants rather than patient services staff doing all of it. The team were looking to match the suggestions from the Clwyd Hart report.

CHC Update

'Patient Community Panels' is the new name for what used to be CHC. Jamie Emery met the Chair and Vice Chair of GHH patient panel group and Mick Corser and Anne Horton.
The groups have come a long way and the structure is now set up to have three representative site groups. There is more to be done around the BHH panel as nothing

exists in that format, currently. They will move away from unannounced ad hoc inspections. They will work with what the site leads are working on, such as certain medical pathways and cancer waiting times. The Terms of Reference have been written following the Deloitte review and refer to governance, heavily.
Mick Corser advised that ex-CHC members are a little concerned now that the group is defunct. They are worried about being site-specific. There has been a difficulty getting people involved, at BHH especially as they have been helped by the Solihull and GHH members doing inspections, etc. Progress has been made and Dawn Chaplin has moved things along well and been civilised in the meetings. There is a lot of experience and expertise in the ex-members of CHC. Frances Linn ran adult Social Services in Birmingham, Mick had scrutiny Chair background and experience of learning disabilities and delayed discharges. Jamie added that the expertise needs channelling in the right area.
GHH patient panel has 25-30 members on the circulation list.
Mick advised that CHC had been the only panel that did training regarding ward visits, etc.
Tom Webster has looked at the ToR and thought that CHC's independence was that worked well. He was worried how things like whistle blowing could take place within the new groups. He thought the panels were top heavy with Trust staff on board. CHC was run efficiently by outside volunteers. Currently, management outweighs volunteers and Tom thought the next generation of volunteers could be hard to establish.
Sam Foster was keen to get lots of people together to talk about the patient experience and spend as much time discussing it as the hospital management team discusses finances. She wanted as much air time at Board as she could secure around quality and safety. Therefore, she has to input lots of structure and accountability to ensure her case holds water at Board.

Sam is planning a big mock CQC inspection at the end of October/beginning of November over a number of days, and volunteers will be asked to do that, before the CQC come back to the Trust in spring next year.
The volunteers can belong to the patient panel or more than one, if they choose. They can join small task and finish groups.
Mike Kelly asked if there would still be ward inspections. Sam said there would and the patient panel groups would still be involved. They will focus on the top themes with an aim to improve areas of concern. Sam wanted a senior nurse or doctor on the panel to keep the link with the Trust.
Jamie Emery said the groups would be sent to areas where there was known to be an issue rather than visit everywhere, indiscriminately.
Jamie advised that the new panel meeting dates have been set up and will be circulated for meetings at the end of October. Catherine Williams will send the dates out and put in the post for those not on email.
David Treadwell asked what authority the Patient Panels will have as the CHC was independent. Sam Foster said that the work would be agreed with them by the panels Trust and they would work to the ToR. The Chest Clinic would join the BHH group.
The Chair for each panel will be elected, along with the Co-Chair. They will work alongside the senior nurse on the relevant site. Jamie Emery and Dawn Chaplin will also be on the panel. There will be co-operation between the three Chairs. Jamie Emery said some registration issues were outstanding but the panels were pretty much already set up; there are already Governors on these panels. All members will have an ID badge. They will also be involved in PLACE visits.

Mick Corser will start as Chair at BHH, Tony Cannon is the Chair at GHH and Solihull is currently vacant. Mike Kelly offered to pick that up.

Only 2 Trust members need to be present but it makes sense for someone to be clinical.

Kath Bell has stepped down from all of her committees, although she is still a Governor.

Tom Webster had been invited to stay on this committee after he had ceased being a Governor. He suggested having ex-Governors on the committees because of their experience. Les Lawrence is looking at extending the length of Governors constitution from 9 years.

David Treadwell sent his regards and that of the meeting to the Chairs of all panels and wished them well.

Any Other Business

Mike Kelly passed around good comment about the catering in Café One in the Birmingham Mail. Jamie Emery offered to take it in to Café One on his way back to his office.

David Treadwell was impressed with Andrew Foster's term at HEFT as he was always visible and, in his opinion, has done a good job.

Next month, Sam Foster will bring the evaluation on Open Visiting to the meeting; she is open to feedback. **Action**

She advised that open visiting had been hugely successful; there has been a reduction in falls since it started.

David Treadwell advised that cleaning needs looking at, as does confidentiality. Also, problems with very late night visiting. Sam advised that all of those areas had been addressed.

Date of Next Meeting

Friday 13th November, 12:00 noon, Education Centre, Solihull Hospital.

Approved minutes

Minutes of a meeting of the

COUNCIL OF GOVERNORS

QUALITY AND RISK

Heart of England NHS Foundation Trust

Education Centre- Heartlands Hospital – Monday 27th July at 10.45am

Present	Title	Initials
Kath Bell	Deputy Chair & Public Governor	KB
Mark Pearson	Public Governor	MP
David Treadwell	Public Governor	DT
Nicola Burgess	Stakeholder Governor	NB
Heidi Lane	Stakeholder Governor	HL
Barry Orris	Public Governor	BO

In attendance:	Title	
Rachel Blackburn	Head of Compliance/Interim Deputy Director of Governance	RB
Louise Rudd	Head of Clinical Governance	LR
Clive Ryder	Deputy Medical Director	CR
Maria Conneely	PA – Minutes	

1.Apologies for absence

Jammi Rao, Sam Foster, Hazel Gunter, Kyriacos Kyriacou, Liz Steventon

2.Minutes of the previous meeting

The minutes were accepted as a true and accurate record.

3. Matters arising from minutes

BO asked what process is in place to ensure Doctors are not exceeding working hours.
CR said that the Trust currently does not have processes in place. Currently there are several issues around Doctors hours, one is around senior medical staff and some are around Consultants who work in excess 48 hours, in the new job policy that issue will be highlighted.
There are two timelines for solving the issues of which one is by October 1st. If consultants and other staff who currently have excess hours in their contract, haven't signed a waiver for the European Working Time Directive, then October 1st is the date they would no longer be able to work those hours.

Some clinical services rely on staff working those extra hours; the Trust need to give the clinical teams some time to sort out, for those who have signed the waiver the deadline is April 2016.

For staff that, under previous HR policy, signed the waiver. The view of the senior medical leadership team is that it is inappropriate for consultants to work for more than 48hrs contractually.

In terms of staff working through an agency the Trust relies on the agency to police the hours worked by their staff. The Trust is currently going through a lot of issues around agency working. There is a code of conduct being produced, essentially it is the Doctor's responsibility to work within the law, but relying on those people is not enough and the Trust needs a method of monitoring this. It is difficult for the agencies because some people may work for more than one agency.

BO asked if a Doctor is excluded, how do you ensure the Doctor does not sign on with another agency and work for another Trust?
CR said if the Trust excluded a member of staff then they are referred to the GMC who put conditions of service upon the staff member, which include: - that they should not work as locums, and they must inform any other employer. If the Trust thinks a member of staff is a real risk then we put out an all-points bulletin, this system is used for example, if there is a problem with a type of drug then to send out a warning to the NHS as a whole, it can also be used to share other types of information. Also if a Trust employs a locum Doctor, they then have to contact the locum's current place of employment to obtain a recommendation from the revalidation officer. The Trust has a duty to share information with revalidation officers at other Trusts.

4.Actions from previous meetings

The committee members reviewed on-going actions: - The action list has been updated.

Action 1.

MP said a meeting was arranged for AC/MP & JR to discuss the Urology case but the meeting was cancelled. CR said the Trust has a list of cases that goes to a closed session of the Board so it can get full scrutiny. We get criticized in two ways, the first for keeping conditions on a person's practice for too long and not drawing investigations to a conclusion, and the second one is that we have a lack of clarity & transparency to the general public.

If someone has GMC restrictions the public can find this out through the GMC or their website. The protection to patients safety is that exclusion is considered, as is restriction of practice. This decision is not taken lightly or by one person and is also reviewed monthly. If we were to inform patients that would be difficult to do in an informed way.

CR explained, how we would give informed consent about the nature of the concerns, the details and the risk attached would be very difficult without further investigation of the facts & issues.

NB said the patients need confidence that the Trust has procedures in place so that if there are any doubts then the Trust will prevent that person from harming patients.

CR said we are more robust now and the patient issue is the priority rather than the career of the Doctor. The default position is why should this person be allowed to carry on rather than why shouldn't they.

MP commented that the point is, " no decision about me without me" and coupled with the Duty of Candour, he has great confidence in AC & CR but they would not always be at the Trust.

The principle is that the patients are entitled to know if the Doctor is under investigation for a clinical matter.

CR said it was difficult, and a balance between people not reporting themselves or other people not reporting. CR will take this to AC.

NB suggested that if someone is under investigation for a clinical matter perhaps one way of gauging this tension is to remove that professional from the area.

CR said the professional is removed from that area of work.

Currently there are complaints against 10% of the consultants at any one time, if we take them out of clinical practice that would have a devastating outcome. Also, the number who actually ends up with long term conditions placed on their practice or being struck off is actually quite small.

NB asked how long does it take for the investigation arising and conclusion? CR stated it usually takes 3 months as a maximum but some investigations become very complicated and take much longer. If there is an anxiety at the initial assessment that there is an issue around patient care then we put restrictions in place at that stage with a view to reviewing them as the concerns are substantiated or otherwise putting restrictions in and taking them away as they become substantiated.

If we took out all the Consultants who have a complaint against them it would be chaos.

If there is a concern raised it comes to AC or myself in a matter of hours or days.

MP said the job of the CoG committees is to give assurance to patients and yet CR feels he cannot say Manu Nair and this is to protect the reputation of Manu Nair but patients should know what is going on.

CR responded to say the investigation has not been concluded. One of the biggest issues is where employment law favours the employee. If it seems the Trust has made a decision before the investigation is complete, when it goes to employment tribunal they may make the wrong decision and allow someone to continue on a technicality rather than what is right. Employment law is written to protect the employee and for the ordinary worker that is fine and just but for Consultants it feels the balance is wrong. The main reason for the Trust in adhering to process is so that disreputable people cannot get away on a technicality.

Action 3.

A discussion took place around CoG receiving all SUI at a glance reports and it was decided to circulate the SUI referring to transfer of neo-natal patient from GHH to BHH for the time being.

5. CQC Report

CR explained the Trust receives initial feedback after a CQC visit, particularly if there are items to sort out immediately. We then receive a draft, which we didn't receive until May. When it is published CQC put it on the website so the Trust do not receive a copy in advance.

Once the report is out, there are three types of actions - requirement actions, which are mandated, must do and should do's.

An action plan is produced to address all of the requirements, all of the must do's and there is discussion and an action plan against for most of the should do's, which is followed up with various owners at local level

and scrutinised at Q&R.

KB asked about one of the points mentioned in the report, re: revalidation of Doctors, the report said the number of referrals of revalidation was worse and it had more than doubled in the current year, 2013-2014 8.5% but in 2014-2015 18.8%. Would this be a concern?

CR said the revalidation process is on track, the Trust had external scrutiny of the revalidation good assurance process and Deloitte have just completed a Board assurance internal audit piece and the Trust has received. The reason for the increase is because when revalidation was first set up we chose staff that we thought were the most engaged to test the system and now we are involving staff who may be less engaged.
Only 6 to 7 people were deferred, as they were slow to engage in the process. There are lots of reasons for being deferred i.e. maternity leave or secondments. So only 6 or 7 individuals were deferred because they had not done their appraisal, and of those only 1 has a disciplinary action in terms of being excluded.

MP asked if the increase in appraisals at 57% to year-end included all staff.
CR explained that appraisals for senior medical staff is 99.9%, the rest of Trust staff appraisals in the CQC report is slightly misleading as the appraisal process is a 12 month process, so we need to know how many staff have had an appraisal in the last 12 months not how many people have had an appraisal since April.

KB asked about re-admission rates April to Sept 2014 – is the Trust back on track?
CR said that we have always been a high re-admission Trust. The implication of having high re-admission is that we are sending patients out too soon. We also used to have excessive lengths of stay, so they could both be right.

CR expressed a view that we have done significant work on length of stay and it's come down from 9 days to just over 7 over the last couple of years and during that time our re-admission rate has remained pretty stable, although high, is a lot of re-admission is around the support outside the hospital for a lot of patients. A lot of people are not re-admitted with the same illness and a cross section of our patients have multiple pathologies plus extreme age. So we may mend one bit, but then over the next 30 days another bit breaks, therefore they come back into hospital again. It is a system issue and at the moment we are the place of safety for patients that need help.
From the Trust point of view it represents a system in crisis rather than a failing of the Trust.

MP asked about learning from incidents/reporting of incidents, the report flagged this up.
CR said the action plan should be submitted to Q&R, which will then become available to CoG.

LR said we could present a survey of learning from Incidents at the next CoG meeting.

BO said the A&E 4 hour target is changing clinical behaviour and thought it was changing in other areas too.
In order to meet targets in T&O for carrying out operations the consultants are continually in theatre and are not carrying out clinics so patients are on waiting lists to see doctors in clinics.
CR said there a tension between having staff available to do the initial assessment and the follow-up.

NB asked what process does the Trust currently use to feedback learning from incidents to staff,
Does it use an internal Twitter?
LR responded that her concern was that we did not know the moderation around Twitter.
There have been several conversations around feedback; we encourage staff to ask the handler of the incident to ask. LR is doing some work with junior Doctors, so if they have experienced a patient safety event, LR will follow up the feedback for them. We are doing work around triangulation, and what we have learnt is when staff ask for feedback they mean the grand scheme of what is happening in the Trust. What is being done to sort out the ED crisis or what is being done about staffing? When we have been involved in an investigation around a serious untoward incident or a local Root Cause Analysis, we really encourage and facilitate the feedback sessions. Part of a project we are doing at the moment is redesigning our incident reporting processes, we are making it much more simple, so staff know who to go to for feedback.

6. Board Q&R minutes – March minutes instead of April minutes were included in error.
7. Safety Sit Rep
Taken as read, and the following questions were asked.
KB asked what validated mean? LR said people can propose that a risk should be categorized as red but at a Friday morning Risk Review meeting, the evidence behind the risk will be challenged, to weed out the ones that are over inflated and aren't actually such a problem. The role is also to ask what is being done

about it and does the action plan match the risk and the level of risk. It becomes validated when the Risk Review group agree with the Risk based on the evidence. Another role of the group is to challenge progress if nothing is happening after a length of time.

BO asked if the Trust has lost JAG accreditation.
LR said no, the team came to the Trust to conduct a review and it remains a risk that we might lose the JAG accreditation.
MP asked why this is a red risk?
KB said endoscopy works 7 days a week.
LR said the issues were, not enough premises, shortage of staff, issues with decontamination of washers, and that this has had an impact on the ability to reduce the waiting list.
MP said he thought the red risk was because the Trust was losing its accreditation.
LR said 5 weeks was too long to wait for a diagnostic endoscopy and the clinical risk was because 5 weeks is too long to wait for a diagnosis.

8 AOB

Liz Steventon has resigned from CoG, it was agreed by all that Liz will be a great loss and missed by all.
MP agreed to be chair of this committee.
KB asked for the latest Deloitte report.

11. Action log

Date of minutes	ACTIONS FROM PREVIOUS MEETINGS	Target date	Owner
1 from Dec 14	Questions to JR: rolling review members of staff under investigation	On going	**MP/JR**
2 from Dec 14	This committee to receive feedback that was given to Trust following the CQC visit as soon as possible- update Jan – delay with report as the person completing the surgical part is unwell. *Update July: the cttee has received feedback.*		**complete**
3 from Dec 14	Report back on SUI referring to transfer of neo-natal patient from GHH to BHH-To bring sui at a glance to May meeting. *Update May: AK to send out end of May* *Update July: LR will pick this up and circulate to CoG.*	July15	**LR**
4 from Jan 2015	LS ask Trust Chairman to invite presentation of Dementia Strategy at future COG and inform KS of proposed Governor representation Dementia Strategy Steering Group dates are: 2nd Tuesday of each month - meetings are 1st Tuesday of every month. David Seaman emailing LS & AL of DSSG details Update May: LS has spoken with Les & Kevin re: Dementia Strategy – coming to full CoGJune15 CoG LS	June15 CoG	**complete**
5 from Jan 15	SF to inform KB of further dates re: night ward visits *Update July: not yet rec'd*	May15	**SF**
6 from Mar 15	SF to send out Delivery unit report that was presented to EMB *Update July: a discussion around this report was had by CoG and LR to ascertain why this report is to be sent to CoG as the report is entirely operational.*	May15	**SF**
7 from Mar 15	SF to invite Nial Ferguson to full COG	June15 COG	**complete**
8 from Mar 15	Pt experience group & linking in with incidents information and safety matters – to schedule a combined meeting to have a debate on how to present reports to COG (integrated reporting) *Update July: LR will link in with Kevin (Pt experience may come through this group, Kevin is currently mapping cttees & looking at Governors Groups) is the issue we want more integrated info going upto CoG. How do we triangulate Info from Incidents, claims, bringing that report through to Q&R.*		**LR**
9 from Mar 15	KB asked if ground level staff have attended Staff Engagement	July15	**LR**

	Events – HG to provide further information when info available *Update May: HG/KK to bring the results of attendance from Bands 1-4 event & Mon comms from CE to be sent to CoG members* *Update July: LR to ask Alex Covey for an update and circulate.*		
10 from Mar 15	From Board Q&R Minutes Nov '14 Report to be circulated to this committee regarding response to Q18. (No response from T&O & Stroke. Has this been followed up as per minutes? *Update May: Stroke have provided a response – T&O have not provided a response -JR to liaise with T&O. A report due to Q&R.* *Update July: KB had the update re: Stroke. T&O invited to Q&R*		**JR**
	Actions from May meeting (11 to 21 not updated in July CoG due to time constraints)		
11 from May 15	LR to provide CoG on how many SUI's (with background info) have occurred in ED over the last 2 yrs.	Sept15	**LR**
12 from May15	Re: ED - JR stated ever since the 4hr target was introduced there has always been a concern that an artificially imposed administratively driven target will change clinical behaviour. JR to ask the Urgent Care Improvement Board to note the concerns of this committee		**JR**
13 From May15	LR to look into keeping a patient in hospital for a longer period if the patient has a failed endoscopy	July '15	**LR**
14 from May15	JR to arrange a meeting with SF, AC & the Governors to air the issue of naming a staff member re: safeguarding cases	July''15	**JR**
15 from May15	KK to clarify the word 'safeguarding' to include extra information on the report with regard to stating the impact to patients or if there was not an impact to patients	July '15	**KK**
16 from May15	Solihull Minor Injuries Unit, staffing Issue - appropriate skill mix/adequate staff. LR to ask what the progress is on this issue and when is it likely to be resolved.	Sept'15	**LR**
17 from May15	Risk: manually winding lifts – manual handling issue. LR to ask John Sellers what the plans are to remedy this issue. Also what are the plans for the lift that has been out of order for many months?	July'15	**LR**
18 From May 15	CQC/Dr Foster alerts - LR to keep this committee informed of new alerts		**LR**
19 from May15	24/7 visiting – report from audit due to Q&R in September JR to bring to CoG once received.	Nov15	**JR**
20 from May15	TTO's – LR to ask Tanya re: poly-pharmacy	July'15	**LR**
21 from May15	A clause in AK TOR so that if AK felt sufficiently concerned she would have direct access to JR *Update July*: there was further discussion.	July ' 15	**AC/KS/JR**
22 From July15	Arranged meeting with MP/AC/JR cancelled by AC re: Nair CR to speak with AC		**CR**
23 From July15	KB asked for the latest Deloitte report- LR to ask RB if there is one. This could be any updates as Deloitte are "closely monitoring" the "Governance Review"		**LR**

Next meeting: Monday 28 September 2015
Room 1 – Solihull Education Centre
10:30am to 1:00pm

Title: Priority Programme for Frailty: Cutting the Costs of Frailty					**Attachments:**		1
From: Prof Ian Philp			**To**: Council of Governors				
The Report is being provided for: Information and assurance							
Decision		Discussion	Y	Assurance	Y	Endorsement	
The CoG is being asked to:							
Review the content of the attached paper which outlines the basis for the HEFT Priority Programme for Frailty. This programme is responsible for the transformation of older people's care at HEFT. The work of this programme is also a significant foundation to the recent successful Urgent and Emergency Care (UEC) Vanguard which was awarded to the Solihull Together partnership in July 2015.							
Key points/Summary:							
The attached Priority Programme for Frailty: Cutting the Costs of Frailty document contains a summary of: • Agreed system wide definitions of Frailty • Principles of redesign including definitions of each element of the pathway • Modelling assumptions • Responsibility graph • Proposed metrics This document has been developed as a result of a series of workshops held with key internal and external stakeholders held during spring and early summer of 2015. There has been significant interest in this model by the national team at NHS England whereby Vanguard facilitates the platform to share and deliver this work at scale and pace.							
Recommendation(s):							
The CoG is asked to consider this paper for information and use this opportunity to ask further questions in regards to the transformation of older people's care.							
Assurance Implications:							
Strategic Risk Register		Performance KPIs year to date					
Resource/Assurance Implications (e.g. Financial/HR)		Information Exempt from Disclosure					

Priority Programme for Frailty: Cutting the Costs of Frailty

Changing the pathways of care for older people can make a significant contribution to cutting the costs of care to the system, reducing overcrowding and pressures on acute services, improving outcomes for older people and their carers.

Our Priority Programme for Frailty Strategy agreed by HEFT and our partners in Birmingham and Solihull is based on six redesign principles and a shared operational and physiological definition of Frailty. These are described below, with an outline of the likely impact on human and financial costs as well as system measures.

Physiological Definition

'Frailty is a condition, seen particularly in older patients, characterized by low functional reserve, easy tiring, decrease of libido, mood disturbance, accelerated osteoporosis, decreased muscle strength, and high susceptibility to disease. People with the frailty syndrome may take a sudden turn for the worse and die. However, the frailty syndrome may sometimes be reversible.'

Operational Definition:

75 years or older and has one or more of the following: (please note, younger frail patients will be considered on needs basis)

- Acute confusion
- Dementia with increasing confusion/delirium
- Reduced mobility and/or falls
- New onset incontinence of urine or faeces
- Multiple co-morbidities (physical and or mental)
- Poly pharmacy
- Patients from residential and nursing homes
- Care package breakdown
- Carer strain
- Safeguarding issue
- New loss of function

Redesign Principles (including definitions and modelling assumptions)

- **Get In Early**

Two thirds of major risks to health, independence and well-being in older people are not recognised. We will develop systematic approaches to identifying these risks in people aged 75 and above and mobilise a response based on the priorities of the older person and their families.

Impact: Based on experience of this approach in the Netherlands, there will be costs of implementing the prevention work in the community and an increase in community support, balanced by reduced acute hospital admissions within six months. Within three to five years, there will be an impact on extending healthy active life with a compression of morbidity, significant reductions in long-term support costs and improved outcomes for older people and their families.

- **Choose to Admit**

There is a two hour 'golden window' when it is possible to provide safe and effective alternatives to admission for many older people with a frailty crisis (e.g. falls, sudden loss of mobility, confusion). We will develop emergency response systems to identifying people with a frailty crisis and build capacity and responsiveness for the provision of safe, effective services in people's homes or in step up intermediate care beds as an alternative to acute hospital admission.

Impact: This approach shifts the balance of care from acute inpatient to community-based support, diverting care for about four out of five presentations with a frailty crisis. Overall the costs to the system are neutral, with improved outcomes for older people.

- **Specialised Acute Care**

Frail older people requiring acute care have improved outcomes if they have early access to care by old age specialists to start the process of Comprehensive Geriatric Assessment (CGA). We will ensure that frail older people in acute settings are identified during emergency response or after surgical intervention, with early involvement of old age specialist teams.

Impact: There will be increased costs from expanding old age specialist teams, balanced by reductions in length of stay, reduced readmissions and improved outcomes for older people.

- **Discharge to Assess**

The majority of adverse events in hospital, such as healthcare-acquired infections and falls occur in older people awaiting discharge or transfer to post-acute care services. We will develop the capacity and responsiveness of community based post acute-care services to ensure that older people can be transferred quickly with simple triage to post-acute settings, with 48 hour follow-up by advanced care practitioners to reset post-acute care plans.

Impact: There will be increased costs in providing early support and 48 hour reviews, but significant savings through reductions in length of stay, and reduced readmissions, with better outcomes for older people.

- **Recovery before Placement**

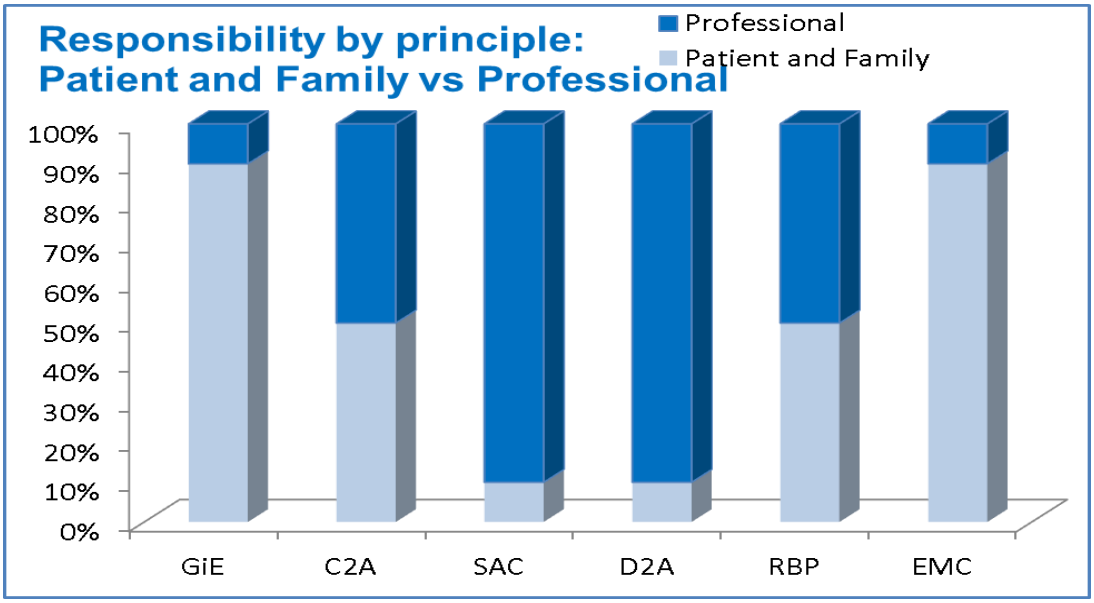
Frail older people take up to six weeks to recover from an acute episode. Decisions about long term support needs during this period are premature and result in avoidable loss of independence and long term care placements. We will develop systems to ensure that all older people recovering from a frailty crisis have access to up to six weeks of rehabilitation and reablement prior to the provision of long term support services.

Impact: There will be increased costs of rehabilitation and reablement services and for medical care in the community, balanced by savings in reduced length of hospital care. The main cost saving to the system will be in reduced long-term care costs of between 10-30% (based on experience of this approach in Australia).

- **Every Moment Counts**

Many frail older people spend most of their last year of life with recurrent admissions to hospital. We will provide an opportunity for all frail older people and their families who receive our services to develop anticipatory care plans for their future treatment options.

Impact: There will be increased costs in providing end of life services in people's homes and care homes, greatly exceeded by cost savings from reduced use of acute hospital care services by frail older people in their last year of life, with much improved patient and carer experience.



Metrics

The programme has developed a set of metrics. Clinical Pathway metrics measure adherence to the principles of redesign as below:

- **Get In Early:** Proportion of Older People over 75 living in their own home who have had a holistic needs Ax
- **Choose to Admit:** Emergency admission rates for urgent conditions that could be managed out of hospital , Adherence to Advanced Care Plans
- **Specialised Acute Care:** Time from first contact to definitive care / senior clinical review
- **Discharge to Assess:** Agreement of a number of patients being pulled from hospital each day (based upon numbers modelling)
- **Recovery before Placement:** Proportion of Older People receiving long term care or placements without receiving care from the post-acute pathway
- **Every Moment Counts:** Proportion of people who have received CGA and have an Advanced Care Plan in place

Other Metrics

Patient Experience:

- Observing practice: 'compassion cards'
- Patient / carer satisfaction / exceed expectations
- Am I treated with dignity and respect? Am I involved in the decisions about my care? Do I know what to do to get help?
- Do I receive timely help?
- Am I safe and confident in the care received?
- People feeling that they get the support that enables them to live as they would like to live in order to meet their health and care needs

Staff Experience:

- Staff turnover, sickness and vacancy rates
- Staff Pressure (unfinished tasks, perceived pressure)
- Quality of communication within the Urgent Care System
- Perceived engagement and development of staff
- Perceived quality of care delivered

Outcomes for Older People:

- Age based levels of independence of Older People
- Age based levels of wellbeing of Older People

Impact on Carers:

- Carers identified
- Carer Screening for Risk
- At Risk Carers Assessed
- Carer Wellbeing

Impact on Flow:

- Discharge to normal place of residence / previous levels of function
- Number of occupied bed days
- Occupancy rates at midnight (below 90%)
- LOS
- Readmission rate
- Re-attendance rate
- 4 hour ED performance (98%)

Impact on Service Utilisation:

- Occupied bed days
- Institutionalisation / long term complex care costs
- Return to former residence